- If this Plan is secondary, the other plan pays benefits first. The amount of Covered Services and the amount payable are determined first, and then the amount of benefits paid by the plan(s) primary to this Plan will be subtracted from the total amount payable for Covered Services.

Determining Which Plan is Primary

When benefits are coordinated between two health care plans, the primary plan pays for Covered Services first before the Participant or the Provider submits the claim to a secondary plan.

To decide which plan pays benefits first, the Plan determines whether it is primary or secondary by applying the following rules in the order they are listed:

1. A plan that has no coordination of benefits provision will be primary.
2. A plan that covers Participants as an Associate or survivor will be primary to a plan that covers them as a Dependent.
3. A plan that covers a Dependent of a person whose birthday is earlier in the calendar year will be primary to one that covers the person as a Dependent of a person whose birthday is later in the calendar year. If the other plan does not have a similar rule, the rule in the other plan will determine which is primary.
4. A plan that covers the Dependent children by court decree in instances where parents are divorced or separated is primary. When no court decree determines medical care responsibility, coverage falls under the parent with legal custody and that plan is primary to the plan of the non-custodial parent. When a custodial parent remarries, the primary plan is determined by:
   - The custodial parent's plan pays benefits first;
   - The stepparent's plan pays next; and
   - The non-custodial parent pays last.
5. A plan covering an individual as an active Associate or Dependent of an active Associate is primary to a plan that covers the individual as a retiree or a former Associate or a Dependent of a retiree or former Associate. If none of these rules apply, the plan that has covered the person the longest is primary.

Always notify the Plan when you or your Dependents obtain coverage under another plan.

Empire will send a letter to Dependents covered under this Plan every 18 months to find out if they have other health coverage. Prior to receiving updated information every 18 months, claims will not be paid and Associates will be notified of the need to update the information. You may update your information by returning the inquiry letter via US mail, by calling the Empire Customer Service at (800) 675-1277, or completing the on-line questionnaire at www.empireblue.com/circuitcity (register for the Blue Tools℠ for Plan Members).

The Working Aged Provision

Persons affected by this provision are:

- Associates age 65 and older
- Associates' spouses age 65 and older

All benefits to which the covered Associate and her/his spouse are entitled under this Plan will be paid before and without regard to any benefits available under Medicare, unless coverage is waived under this Plan. Those who have not enrolled in Medicare can do so when coverage ceases under this Plan.

If an Associate waives coverage and later decides to enroll, the covered Associate and all covered Dependents will be subject to all Plan provisions, including Pre-existing Condition limitations. If a covered Associate and her/his spouse

Vision Care Plan

VSP Vision Care Plan

VSP
(800) 877-7195
www.vsp.com

The Vision Care Plan provides an affordable way to maintain good health through proper vision care. A regular eye exam once a year is a key step in protecting the priceless asset that is your vision. Eye exams not only assess the overall health of your eyes, they can sometimes uncover major health problems such as diabetes and high blood pressure.

The Plan covers an annual eye examination to assess your visual functions and prescribe corrective eyewear when needed. Coverage is provided for a new pair of lenses and a frame each year. An annual allowance is also available for contact lenses, which may be chosen instead of spectacle lenses and frames.

The Plan does not require that you use a VSP Network Provider; however, if you choose to go to a Non-network Provider, you may pay higher costs. Expenses charged to you by Non-network Providers are reimbursed by the Plan according to the covered services overview.

VSP's network of providers is extensive. To find a provider, go to www.vsp.com or call (800) 877-7195.

Eligibility and Enrollment

Associate Eligibility

- Regular Full-time Associates are eligible for coverage under this Plan the first of the month after completing one calendar month of service.
- Regular Part-time Associates are eligible for coverage under this Plan the first of the month after completing one year of continuous service.

Dependent Eligibility

- Regular Full-time Associates may cover eligible Dependents, including spouse, domestic partner and eligible Dependent children.

Special Note for Part-time Associates: If you do not work enough hours to pay for your bi-weekly deductions for two consecutive pay cycles, your coverage will be dropped.

If you want to enroll after the eligibility timeframes, contact the Associate Service Center and ask for an Enrollment Request Form. The form must be completed before the enrollment request will be considered. If your claim initiation/appeal to add coverage after the eligibility timeframe is approved, your benefit deductions will be taken on an after-tax basis for the remainder of the Plan Year.

When Coverage Ends

Associate Coverage

Unless otherwise specified in this SPD, Associate coverage ends on the earliest of the following:

- The last day of the month in which your employment ends, including retirement
- The last day of the month in which eligibility stops
- The last day of the month in which you become covered under another plan (once you notify the Associate Service Center)
- When required contributions stop being made
- When the Plan ends

Dependent Coverage

Unless otherwise specified in this SPD, Dependent coverage ends on the earliest of the following:

- The last day of the month in which eligibility ends for you
- The last day of the month in which a Dependent no longer meets the definition of an eligible Dependent*
- The last day of the month in which coverage ends
- When required contributions stop being made
- When the Dependent becomes covered as an Associate under this Plan or another plan*
- For a spouse, the last day of the month of divorce or annulment*

**It is the Associate's responsibility to notify the Associate Service Center of these events.*

If the Associate dies while covered, eligible Dependents' coverage will continue under COBRA for up to three months after death at no cost to the family.

Continuation of Coverage during a Leave of Absence

According to the Company's Associate Leave Standard Operating Policy, while you are on a leave of absence, your Dental Care Plan benefits will continue for the first six months of your leave as long as you remain eligible. If you do not return from leave after six months, you may elect to continue your coverage under COBRA for an additional 18 months. If you are on Military Leave, you may elect to continue your active coverage for up to twelve months at the same cost as active associates and may then continue coverage at the cost provided under COBRA for an additional 18 months (see Associate Leave Standard Operating Policy for details).

You may not change, drop or add dental coverage during a leave of absence, unless you experience a Qualified Family Status Change. Then you must follow the guidelines for changing coverage depending on the type of event. Refer to the "Qualified Family Status Change" section at the beginning of this booklet for more information.

If you become eligible to participate in the Plan while you are on a medical leave of absence, you must still enroll within the applicable enrollment periods. Effective dates will also be the same as if you were actively working. If you fail to enroll within the applicable enrollment periods, then you must wait until the next annual enrollment unless you experience a Qualified Family Status Change or an event that qualifies for special enrollment.

COBRA

If coverage for you and/or your Dependents ends, eligibility to continue group coverage under COBRA may apply. This optional continuation of group health care coverage is available as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Refer to the "Continuation of Coverage" section at the beginning of this booklet for more information.

Recovery of Third Party Liability Claims

The Plan has the right to reimbursement from covered Associates, their Dependents, or another legally responsible person or entity for all benefits paid by the Plan that were associated with an Injury or Illness for which a third party is liable to the Participant. The Plan has the first priority right to reimbursement from any insurance coverage, including recovery from Uninsured or Underinsured Motorists coverage, judgment, settlement or otherwise. This right to reimbursement remains in effect whether such payment satisfies, in full or in part, the Participant's loss (i.e., regardless of whether the Participant has been "made whole" by the payment) or regardless of how a recovery is characterized. The reimbursement to the Plan shall not be reduced due to the fees or expenses of legal counsel retained by the Participant.

If the Participant or any other person or organization that was paid does not promptly reimburse the full amount, the Plan may reduce the amount of any future payable benefits. Participants have the same obligations as listed under the "Subrogation" section of this SPD.

Reductions will equal the amount the Plan paid in excess of the amount it should have paid. In the case of recovery from a source other than this Plan, the refund will equal the amount of recovery up to the amount paid under this Plan. The Plan may have other rights in addition to the right to reduce future benefits.

Subrogation

Subrogation is a cost-containment feature that shifts the expense of treating accidental injuries back to the party or insurer properly responsible for those costs. When the Plan pays for accidental injuries, subrogation allows the Plan to recover, by legal action if necessary, those payments directly from the responsible third party.

Subrogation will result in savings to the Plan for the benefit of all Participants because the cost of treatment for sickness or Injury will be paid by the person who is legally responsible for such payment. The Plan is also subrogated and has a right of subrogation to any underinsured, insured, uninsured or any other insurance plan under which Participants are covered.

Any settlement which releases all the claims Participants have against any of the parties noted above is deemed to be for damages on account of the expenses incurred as a result of the Injury or Injuries, no matter how the settlement documents may denominate the settlement and regardless of whether the injured Participant is fully compensated ("made whole"). The Plan's recovery shall not be reduced due to the fees or expenses of legal counsel retained by the Participant.

Under this subrogation provision, Participants have the following obligations:

- To seek recovery from a third party (or her/his insurance) of all amounts in connection with Plan benefits provided, arranged or paid, and to notify the Plan within 10 working days of any such action taken by him/her.
- To refrain from doing anything to impair, prejudice or discharge the Plan's right of subrogation.
- To assist the Plan as necessary to enforce its right of subrogation.
- To pay the Plan any amounts received to the extent of benefits provided by the Plan to which the Plan is entitled because of its right of subrogation.
- To provide in a timely fashion, information requested by the Plan.

Determining Which Plan Is Primary

When benefits are coordinated between two dental care plans, the primary plan pays for Covered Services first before the Participant or provider submits the claim to a secondary plan. To decide which plan pays benefits first, the Plan determines whether it is primary or secondary by applying the following rules in the order they are listed:

1. A plan that has no coordination of benefits provision will be primary.
2. A plan that covers Participants as an Associate or survivor will be primary to a plan that covers them as a Dependent.
3. A plan that covers a Dependent of the person whose birthday is earlier in the calendar year will be primary to one that covers the person as a Dependent of a person whose birthday is later in the calendar year. If the other plan does not have a similar rule, the rule in the other plan will determine which is primary.
4. A plan that covers the Dependent children by court decree in instances where parents are divorced or separated is primary. When no court decree determines medical care responsibility, coverage falls under the parent with legal custody and that plan is primary to the plan of the non-custodial parent. When a custodial parent remarries, the primary plan is determined by:
   - The custodial parent's plan pays benefits first.
   - The stepparent's plan pays next.
   - The non-custodial parent pays last.
5. A plan covering an individual as an active Associate or Dependent of an active Associate is primary to a plan that covers the individual as a retiree or a former Associate or a Dependent of a retiree or former Associate. If none of these rules apply, the plan that has covered the person the longest is primary.

Always notify the Plan when you or your Dependents obtain coverage under another plan.

The Working Aged Provision and Medicare

Persons affected by this provision are:

- Associates age 65 and older
- Associates' spouses age 65 and older

All benefits to which the covered Associate and her/his spouse are entitled under this Plan will be paid before and without regard to any benefits available under Medicare, unless they waive coverage under this Plan.

If an Associate waives coverage and later decides to enroll, the covered Associate and all covered Dependents will be subject to all Plan provisions, including Pre-existing Condition limitations. If a covered Associate and her/his spouse remain covered under this Plan, each should enroll in Medicare when first eligible. Medicare may pay certain benefits in addition to those under this Plan. Additionally, late enrollment in Medicare may result in a continuing surcharge on Medicare premiums after enrollment.

Refund to the Plan for Overpayment of Benefits

Whenever payments have been made by the Plan in excess of the maximum amount payable under the Plan's provisions, Participants must reimburse the Plan for the amount paid in excess.

If the Participant or any other person or organization that was paid does not promptly reimburse the full amount, the Plan may reduce the amount of any future benefits payable. The reductions will equal, but not exceed, the amount the Plan paid in excess of the amount it should have paid. The Plan may have other rights in addition to the right to reduce future benefits.

Claims and Appeals Review

Aetna will review your claim and make a decision within the allowable timeframe listed below.

Type of Claim	Decision Timeframe for Review of Claims and Appeals
Urgent Claims	The Plan will notify you within 72 hours of any denial. If additional information is needed, the Plan will notify you within 24 hours and allow you 48 hours to respond. The Plan will make a determination within 48 hours of the earlier of: receipt of the information or the end of the period you were given to provide information. The Plan will make a decision on any appeal within 72 hours.
Concurrent Claims	The Plan must notify you prior to the end of an authorized treatment if the benefit is reduced or terminated. If you request to extend a treatment beyond the prescribed course and it involves an urgent care claim, you must make the request at least 24 hours prior to the end of the prescribed treatment and the Plan will make a decision within 24 hours of receipt of your request. If you request to extend a treatment and it does not involve an urgent care claim, the Plan will make a decision within 15 days. You will have 180 days following receipt of a denial to request an appeal. The Plan will make a decision on any appeal within 15 days, or if it involves an urgent care claim, within 72 hours. You will have 60 days following receipt of a denial to request a second appeal. The Plan must make a decision on the second appeal within 15 days.
Pre-service Claims	The Plan must notify you within 15 days of any denial, or send written notice for a 15-day extension. If an extension is needed due to lack of information from you, you will have 45 days from receipt of the notice to provide the information. You have will 180 days following receipt of a denial to request an appeal. The Plan must make a decision on any appeal within 15 days. You will have 60 days following receipt of a denial to request a second appeal. The Plan must make a decision on the second appeal within 15 days.
Post-service Claims	The Plan must notify you within 30 days of any denial, or send written notice for a 15-day extension. If the extension is needed due to lack of information from you, you will have 45 days from receipt of the notice to provide the information. You will have 180 days following receipt of a denial to request an appeal. The Plan must make a decision on any appeal within 30 days. You will have 60 days following receipt of a denial to request a second appeal. The Plan must make a decision on the second appeal within 30 days.

Coordination of Benefits

Aetna coordinates benefits with other health plans in which you or your Dependents may participate. Other plans include:

- Another employer group health plan
- A plan resulting from the No-fault Automobile Insurance Law
- A government or tax-supported program, excluding Medicaid

Benefits from this Plan will be determined so that when they are combined with benefits from any other plans, they will not exceed that which would have been paid under this Plan if no other coverage existed.

- If this Plan is primary, it will pay benefits first. Benefits under this Plan will not be reduced due to benefits payable under other plans.
- If this Plan is secondary, the other plan pays benefits first. The amount of Covered Services and the amount payable are determined first, and then the amount of benefits paid by the plan(s) primary to this Plan will be subtracted from the total amount payable for Covered Services.

Submit written appeals to:

Aetna
P.O. Box 14066
Lexington, KY 40512

You must submit your appeal within 180 days from receipt of the denial or you waive your right to request a review of the denied claim.

Refer to the "Claims" section at the beginning of this booklet for additional information about denied claims and what to expect from the Plan.

Appeals submitted after the deadline for submission will not be reviewed again and the preceding decision will stand.

Dental Care Self-Audit Bonus

The Dental Care Self-Audit Bonus rewards Participants for their efforts in helping to control excess billing costs. Your dental bill can include errors, such as charges for X-rays that were not given, dental supplies or appliances not used, or procedures that were not performed.

Review (audit) all dental bills and EOBs to make sure they are correct. Ask for an itemized bill from your dentist at the time of service. If you find an error in the bill after the claim is paid or if the claim is processed incorrectly, the Company will pay you 50% of the first $200 saved and 25% over $200. The maximum self-audit bonus is $1,000.

Example: If you find an error that the Plan paid $300 more than it should have, the Company will pay you a bonus of $125 (50% of $200 plus 25% of $100).

If you find an error on a dental bill:

1. Contact the dentist's office to determine the correct charge,
2. Confirm the adjustment of charges; and
3. Send your request for a self-audit bonus along with the original bill, the revised bill and EOB to:

   Circuit City Stores, Inc.
   Attn: Benefits Department
   9954 Mayland Drive
   Richmond, VA 23233-1463

Self-audit bonus requests should be submitted within 12 months from the date services were received.

To file an initial claim for dental service, follow these steps:

1. Call the Associate Service Center at (800) 288-6353 or go to the Forms Library at www.aetna.com to obtain a claim form.
2. Complete the claim form. A separate claim form must be completed for claims being submitted for each Covered Family Member. The provider must complete the front portion of the form. If you want the benefit payments made directly to your dentist, sign the line on the claim form to authorize direct payment.
3. Attach all itemized bills to the claim form.
4. Make copies of all bills and claim forms. It is important to keep records for each Covered Family Member.

Mail the original claim form and itemized bills to:

Aetna
P.O. Box 14066
Lexington, KY 40512

Only claims submitted within 15 months following the date of service will be accepted.

Payment of Claims

After Aetna receives the completed claim information, payment will be made to the appropriate payee:

- Directly to the provider when the provider assumes responsibility for the claim; or
- Directly to the Participant for reimbursements of qualified payments made by the Participant.

Benefits for covered Dependents after the covered Associate's death will be paid to one of the following:

- The surviving spouse;
- The Dependent child who is not a minor, if there is no surviving spouse;
- A provider or a person who makes charges to Dependents for services covered under this Plan; or
- The legal guardian of the Dependent.

Explanation of Benefits (EOB)

For each claim processed, an explanation of benefits is mailed to the Participant. The EOB lists the amount of the charge, the amount covered, the amount applied to the Deductible, Coinsurance, and network adjustment, if applicable, and the amount to be paid. Keep EOBs for your records. EOBs are always available online at www.aetnanavigator.com.

Filing an Appeal

You have the right to appeal any denied claim. You may authorize, in writing, a representative to act on your behalf in filing your appeal. Your appeal must be in writing and should include:

- The covered Associate's name, address and telephone number
- All information from the covered Associate's ID card as it appears
- The name of the person for whom the claim applies and the date of service
- The name and contact information for the provider and place of service
- Description of the service and the charge for the service
- Statement of opinion as to why the denial was improper
- A copy of the EOB (if available)

- Dietary planning, plaque control, oral hygiene instructions, treatment for the correction of any congenital or developmental malformation
- Expenses in connection with a service furnished for cosmetic purposes. Facings on crowns or pontics that are behind the second bicuspid will always be considered cosmetic. This does not apply if the service is needed as a result of accidental injuries due to external force sustained while a person is covered.
- Expenses not recommended or prescribed by a dentist or Physician
- Expenses for any of the following services:
  - An appliance, or modification of one, if an impression for it was made before the person became covered
  - A crown, bridge or gold restoration, if a tooth was prepared for it before the person became covered
  - Root canal therapy, if the pulp chamber for it was opened before the person became covered
- Replacement of existing full or partial dentures, bridgework or crowns unless:
  - They are required because of the extraction of one or more natural teeth after the effective date of coverage
  - The existing denture, bridgework or crown is at least 5 years old and cannot be made serviceable, and is replaced 12 months or more after the effective date of coverage for the individual
  - The existing denture, bridgework, or crown was temporarily installed after the effective date of coverage for the individual and is replaced by a permanent appliance within 12 months
  - The replacement denture, bridgework, or crown is necessary to restore proper occlusion as a result of an initial placement of an opposing denture while insured
  - The replacement denture, bridgework, or crown is made necessary as the result of an accidental Injury while insured (chewing injuries are not considered accidental injuries)
- Treatment received from a dental or medical department maintained by the employer, a mutual benefit association, labor union, trustee or similar type of group
- Expense of dentures or appliances which have been lost or stolen
- Expense of dental treatment required as a result of any self-inflicted Injury, war, or engaging in a riot or insurrection
- Charges made by a dentist for broken appointments or for completion of claim forms
- Charges for any procedures or materials which are in excess of the charge for the least costly procedure or materials that will, as determined by the claims administrator, produce a professionally satisfactory result
- Amounts in excess of the Reasonable and Customary Charge for a service
- Dental treatment for Temporomandibular Joint Pain Dysfunction Syndrome (TMJ), except for splints and appliances. If orthodontic in nature, the expenses are limited to the orthodontic lifetime maximum.

Claims

Filing a Claim

Each time you visit the dentist, you or your dentist must complete a claim form and submit it to Aetna. Claims must be submitted in a timely manner according to the deadlines listed below.

TYPE OF CLAIM	SUBMISSION DEADLINE
Initial Claims	Within 15 months following the date of service
First Level Appeals	Within 180 days from the date of the decision on your initial claim
Second Level Appeals	Within 60 days from the date of the first level appeal decision

  - Dentures and partials (Fees for dentures, partial dentures and relining include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.)

- Orthodontic care (Deductible applies)
  - Orthodontic treatment rendered by an Orthodontist for the correction of Classes I, II, or III malocclusions in relation to a primary, mixed or permanent dentition, including the necessary orthodontic appliances. Dependent children for purposes of orthodontic care are those who remain eligible Dependents throughout the course of treatment.
  - Benefits will be payable only for quarterly installments which occur while the Dependent is covered under the plan
  - If orthodontic treatment commenced prior to the effective date of coverage under this Plan, benefits under this Plan will be offset by benefits paid/available under any other group plan; the maximum benefit for all Plans combined will not exceed $1,500
  - If the Plan commenced payments for orthodontic treatment and the coverage for the Dependent receiving the treatment terminates, orthodontic benefits will be continued until the earlier of the date on which maximum benefits have been received, or the date which is three months immediately following termination of coverage

Orthodontic Treatment Plan
Orthodontic treatment is normally rendered over a long period of time; therefore, Covered Expenses are considered to be spread over the treatment period as specified below, regardless of the way in which the orthodontist's bill is actually paid. Plan benefits are paid on a quarterly basis subject to the Deductible and Coinsurance, and the Dependent's continued eligibility for orthodontic benefits (refer to "Orthodontic Care" for additional information).

The total estimated eligible charges for an orthodontic treatment plan will be considered made and incurred in installments over the estimated duration of the orthodontic treatment plan in these amounts and at these times:

- Amounts: The installments, except the first, will be equal. The first will be twice each of the others.
- Times: The date the appliances are first inserted, at the end of the three-month period starting with that date, and at the end of each of the following three-month periods.

If the actual eligible charges for the orthodontic treatment plan are less than or more than the estimated eligible charges, the last installment above will be reduced by any excess of estimated over actual; or increased by any excess of actual over estimated, up to the Plan maximum.

Exclusions

Covered dental expenses do not include and no payment is made for the following:

- Treatment paid for directly and indirectly by any government or for which a government prohibits payment of benefits
- Injury sustained while working for pay or profit other than with this employer
- Any portion of your dental expenses for which you are covered under Workers' Compensation or some similar program
- Services received in a government Hospital unless you are required to pay for such services
- Services to which the patient is entitled without charge, or for which there would be no charge if there was no insurance
- Services for which you are covered by another plan offered by the Company
- Expenses for a service not reasonably necessary, or not customarily performed, for the dental care of a specific condition of the covered person

- Endodontics, including:
  - Pulp capping
  - Therapeutic pulpotomy (in addition to restoration)
  - Vital pulpotomy
  - Remineralization (calcium hydroxide, temporary restoration) as a separate procedure only
  - Root canals (devitalized teeth only), including necessary x-rays and cultures but excluding final restoration
- Restorative dentistry up to the calendar year maximum (excludes inlays, crowns, other than stainless steel, and bridges). Multiple restorations in one surface will be considered as a single restoration.
  - Restorations (involving one, two or three or more surfaces)
  - Pins
  - Crowns (stainless steel) when tooth cannot be restored with a filling material
  - Full and partial denture repairs
  - Adding teeth to partial denture to replace extracted natural teeth
  - Recementation
  - Repairs to crowns and bridges
- Space Maintainers (limited to children under age 19). Includes all adjustments within six months after installation, as well as:
  - Fixed space maintainer (band type)
  - Removable acrylic with round wire rest only
  - Splints and Appliances
  - Removable inhibiting splints and appliances to correct conditions including but not limited to grinding, clenching or thumb sucking
  - Fixed or cemented inhibiting appliances to correct conditions including but not limited to grinding, clenching or thumb sucking
  - Splints and appliances for the treatment of TMJ
  - Other clinically necessary splints and appliances to correct conditions including but not limited to grinding, clenching and thumb sucking
  - Necessary adjustments to the above listed splints and appliances

- Major care (Deductible applies), up to the calendar year maximum, including
  - Restorative services and supplies, including:
    - Crowns and gold restorations are covered only as treatment for decay or traumatic Injury and only when teeth cannot be restored with a filling material or when tooth is an abutment to a fixed bridge
    - Inlays and onlays
    - Crowns (temporary crowns are considered an integral part of the final restoration)
    - Crown build-up and lengthening
  - Implants
    - Procedure covered up to the amount that would have been paid if a bridge had been placed
  - Prosthodontics
    - Bridge abutments
    - Pontics
    - Removable bridge (unilateral)

For services and supplies not covered, refer to the "Exclusions" section. The Participant and her/his dentist share responsibility for deciding which services and supplies are received. However, the Plan provides benefits only for Covered Services. A service or supply may not be Medically Necessary as defined by the Plan if a less intensive or more appropriate diagnostic or treatment alternative could have been used. The recommendation and approval of the attending dentist does not mean the service or supply is Medically Necessary as defined by the Plan.

The Plan covers the following services and supplies:

- Preventive care (no Deductible, if services are received in-network), including visits and X-rays (except diagnostic X-rays):
  - Office visit during regular office hours for oral examination (limited to two visits every Plan Year)
  - Prophylaxis treatments to include scaling and polishing (limited to two treatments every Plan Year, but not more than once in any five-month period)
  - Topical application of fluoride, including prophylaxis (limited to children under age 19, one application per Plan Year)
  - Bite-wing X-rays (limited to two sets per Plan Year)
  - Entire denture series of X-rays consisting of at least 14 films, including bitewings, if necessary (limited to once every three Plan Years)
  - Panoramic survey, maxillary and mandibular (considered an entire denture series)
  - Decay-preventing sealants applied to permanent molars (limited to children up to age 15)
  - Expenses incurred as a result of accidental injury to natural teeth due to external force, except where other coverage applies
- Basic care (Deductible applies), including visits, exams and X-rays:
  - Professional visit after regular office hours (payment will be made on the basis of services rendered or visit, whichever is greater)
  - Special consultation by a specialist or case presentation when diagnostic procedures have been performed by a general dentist
  - Diagnostic X-rays
  - Emergency palliative treatment
  - Oral surgery (as well as local anesthetics and routine postoperative care), including:
    - Extractions
    - Removal of impacted teeth
    - Alveolar or gingival reconstructions
    - Treatment for odontogenic cysts and neoplasms
    - Other surgical procedures
  - General anesthetics, only when provided in conjunction with a surgical procedure
  - Periodontics, including:
    - Emergency treatment (periodontal abscess, acute periodontitis, etc.)
    - Subgingival curettage or root planning and scaling, per quadrant (not prophylaxis), limited to four quadrants per Plan Year
    - Correction of occlusion related to periodontal surgery, per quadrant
    - Gingivectomy (including post-surgical visits), per quadrant
    - Gingivectomy, treatment per tooth (fewer than five teeth)
    - Osseous or muco-gingival surgery (including post-surgical visits)

Covered Services Overview Continued

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Restorative Denistry (i.e., full and partial denture repair)	80%	50%
General Anesthesia (when provided in conjunction with a covered surgical procedure)	80%	50%
Major(subject to deductible)		
Full and Partial Dentures	60%	50%
Implants[1]	60%	50%
Crown lengthening and build-up	60%	50%
Inlays, Onlays and Crowns (other than Stainless Steel)	60%	50%
Orthodontic Coverage (subject to deductible)		
Orthodontic Treatment (Adult and Child)	50%	50%
Lifetime Maximum Benefit (in addition to the annual benefit maximum)	$1,500	

[1]Covered up to the amount that would be paid for a bridge placement.
**Not subject to Deductible*

Predetermination of Benefits

Before your dentist starts a course of treatment, you should request that she/he prepare a "pretreatment estimate." The pretreatment estimate is a written report describing recommendations for the necessary treatment and cost. The estimate enables the insurance carrier to determine, in advance, if and at what benefit level the services are covered by the Plan. The claims administrator will notify you of the costs you will be responsible for paying.

Always submit a pretreatment estimate to Aetna for any care expected to cost more than $300 and for all orthodontic care.

Mail pretreatment estimates to:

Aetna
P.O. Box 14066
Lexington, KY 40512

Covered Services and Supplies

Services are covered in accordance with Aetna's established standards for the service or supply received. The service or supply must be:

- Required for treatment; and
- Recommended and approved by the attending dentist, unless noted otherwise in the Covered Services listed on the following pages.

If you have questions about Covered Services and/or exclusions, call Aetna Member Services at (800) 843-3661 for more information.

The Plan pays benefits in accordance with established standards for the services and supplies received, subject to applicable Deductibles, Coinsurance, and the annual benefit maximum.

Payment for expenses incurred by you or your Dependents for services and supplies will be made on the basis of the Plan provisions in effect at the time the expenses are incurred:

- For an appliance or alteration of an appliance: on the date the appliance is seated.
- For a crown, bridge, or gold restoration: on the date the tooth is seated.
- For root canal therapy: on the date the pulp chamber is opened.
- For all other dental services: on the date the service is received.

The Plan encourages preventive care by paying 100% of those charges in-network and 80% of the charges out-of-network to help you and your family maintain healthy teeth and avoid costly dental problems.

Plan Provisions and Coinsurance

The Dental Care Plan covers certain preventive, basic and major dental services as listed in the Covered Services Overview (Deductibles, Coinsurance and restrictions apply)

Plan Provision	In-Network Participant Pays	Out-of-Network Participant Pays
Annual Deductible	$50/person $100 maximum/family	
Annual Benefit Maximum (per Participant)	$1,500 (does not include orthodontics)	

Covered Services Overview

Covered Services	In-Network	Out-of-Network
Preventive		
Office Visit for Oral Examination, limited to two visits per year	100%*	80%, after $50 deductible
Bite-Wing X-rays, limited to two sets per year	100%*	80%, after $50 deductible
Prophylaxis, including scaling and polishing, limited to two times per year	100%*	80%, after $50 deductible
Fluoride, children under age 19, limited to one application per year	100%*	80%, after $50 deductible
Sealants, children under age 15, one application every three years for permanent molars only	100%*	80%, after $50 deductible
Basic (subject to deductible)		
Amalgam and Composite Fillings	80%	50%
Diagnostic X-rays	80%	50%
Stainless Steel Crowns (primary teeth)	80%	50%
Endodontics (i.e., root canals, pulpotomy)	80%	50%
Periodontics (i.e., gingival curettage)	80%	50%
Surgery (i.e., extractions, removal of impacted teeth)	80%	50%
Space Maintainers, children under age 19	80%	50%

- **Coinsurance** – The percentage amount of the charge for Covered Services and supplies that you must pay after the Deductible is met. The Plan typically pays the remaining percentage of the covered expense.
- **Covered Services** – Those services for which the Plan will pay a portion of the cost.
- **Lifetime Orthodontic Maximum** – The maximum amount that the Plan pays for orthodontics. The Plan allows a lifetime orthodontic maximum of $1,500 per covered member.
- **Network Provider** – A dental care provider who belongs to Aetna's nationwide Preferred Provider Organization (PPO). The Plan pays a higher level of benefit when you use Aetna Network Providers versus Non-network Providers who are not affiliated with the insurance carrier. Network Providers file claims on behalf of covered Participants.

To find a local dentist in the Aetna PPO Network, call the toll-free number on your Dental ID card, (800) 843-3601, or go to www.aetna.com and search under DocFind®. Use the Dental PPO Plan option under "Dentists" to find a Network Provider.

- **Plan Year Deductible** – Amount paid for certain Covered Services before the Plan begins to pay benefits for that service(s).
  - For Associate only coverage, you must meet the $50 Deductible separately each Plan Year.
  - For family coverage, any combination of expenses for all Covered Family Members applies toward meeting the $100 Deductible, regardless of family size. However, no one individual needs to meet more than the individual $50 Deductible.
- **Reasonable & Customary Charges** – The amount the dental plan claims administrator determines to be at the prevailing rate for a service or supply in the geographic area, or a similar geographic area, in which it is provided. When you receive services from a participating provider, the provider accepts the negotiated rate. When you receive services from a non-participating provider, the Plan pays benefits based on Reasonable and Customary Charges, and you are responsible for paying any amounts above Reasonable and Customary Charges. In determining the Reasonable and Customary Charge for a service or supply that is complex, not often provided in the area, or provided by only a small number of providers in the area, the dental plan claims administrator may take into account factors such as the:
  - Complexity;
  - Degree of skill needed;
  - Type of specialty of the provider;
  - Range of services or supplies provided by a facility; and
  - Prevailing charge in other areas.

  Charges, fees and expenses that are in excess of Reasonable and Customary Charges do not apply to the annual Deductible and are the patient's responsibility to pay.

Dental Care Plan Highlights

The Dental Care Plan is designed to help pay for your dental care by covering a wide range of dental services, referred to as Covered Services, including many preventive care services. Benefits are available for dental expenses that are considered necessary, the most cost effective and appropriate. If you and your dentist choose a more costly procedure, the Plan will pay up to the amount allowed for the least costly procedure that will produce a professionally satisfactory result, as determined by the claims administrator.

- If you are a Regular Part-time Associate, you must complete the on-line enrollment process within 30 days prior to your eligibility date, during annual enrollment or upon/after a Qualified Family Status Change

Types of Coverage

When you enroll, select your type of coverage depending on the number of eligible individuals to be covered.

TYPE OF COVERAGE	ELIGIBLE INDIVIDUALS
Associate	Associate only
Associate and Child(ren)	Associate and eligible Dependent child(ren)
Associate and Spouse/Domestic Partner	Associate and spouse or domestic partner only
Family	Associate and spouse or domestic partner and one or more eligible Dependent child(ren)

Call the Associate Service Center at (800) 288-6353 for questions about eligibility and enrollment.

ID Cards

After the effective date of coverage, you will receive one ID card for Associate only coverage. For all other types of coverage, you will receive two ID cards with the covered Associate's name on them. Your ID Card gives you and your Dependents access to dental care providers throughout the United States.

Always show your ID card to your dental care provider to receive full Plan benefits.

If you or your Dependents need dental services after the effective date of coverage begins, but before receiving ID cards, you can download a temporary dental ID card from www.aetna.com. With the temporary ID card, many providers will submit claims for you. If the provider will not submit your claim, you will need to submit the claim for reimbursement. Refer to the section titled "Claims" for more details.

Aetna Navigator Website

Aetna has a comprehensive website with tools and resources to help you manage your health. You can access your explanation of benefits (EOBs), temporary ID cards, claims history, network directory, as well as a treatment cost advisor to help you estimate your costs for a particular service. Simply go to www.aetnanavigator.com to access the resources and tools provided by Aetna.

Terms to Know

Your coverage with the Dental Care Plan takes into account several factors when determining the expense to you. As you review coverage and expenses, it will help to know the terms listed below. Additional important terms found throughout this Dental Care Plan section are defined in the Glossary at the back of this booklet.

- **Annual Maximum Benefit** – A cap on the amount of expenses that the Plan pays for your dental care. The Plan allows a maximum annual benefit of $1,500 per covered individual. Other maximums for certain services and supplies may apply.

Traditional Dental Care Plan

Aetna Dental Care Plan

Aetna
(800) 843-3661
www.aetna.com

The Dental Care Plan is a Preferred Provider Organization plan administered by Aetna. Aetna's preferred dental care providers agree to offer discounted fees to Dental Care Plan Participants. The Plan does not require that you use Network Providers; however, if you choose to go to a Non-network Provider, you will pay higher costs. In addition to a lower level of benefits, expenses charged by Non-network Providers are reimbursed by the Plan according to what is Reasonable and Customary for the services and supplies you receive from that provider. Your out-of-pocket expenses may be substantially different and higher for Non-network Providers, versus the discounts that you will receive from Network Providers.

To find a local dentist in the Aetna PPO Network, call the toll-free number on your Dental ID card, (800) 843-3661, or go to www.aetna.com and search DocFind®. Use the Dental PPO Plan option under "Dentists" to find a Network Provider.

Eligibility and Enrollment

Associate Eligibility

- Regular Full-time Associates are eligible for coverage under this Plan the first of the month after completing one calendar month of service.
- Regular Part-time Associates are eligible for coverage under this Plan the first of the month after completing one year of continuous service.

Dependent Eligibility

- Regular Full-time Associates may cover eligible Dependents, including spouse, domestic partner and eligible Dependent children.

Special Note for Part-time Associates: If you do not work enough hours to pay for your bi-weekly deductions for two consecutive pay cycles, your coverage will be dropped.

If you want to enroll after the eligibility timeframes, contact the Associate Service Center and ask for an Enrollment Request Form. The form must be completed before the enrollment request will be considered. If your claim initiation/appeal to add coverage after the eligibility timeframe is approved, your benefit deductions will be taken on an after-tax basis for the remainder of the Plan Year.

How and When to Enroll

- If you are a Regular Full-time Associate, you must complete the on-line enrollment process within 30 days after your date of hire, during annual enrollment or upon/after a Qualified Family Status Change

return from leave after six months, you may elect to continue your coverage under COBRA for an additional 18 months. If you are on Military Leave, you may elect to continue your active coverage for up to twelve months at the same cost as active associates and may then continue coverage at the cost provided under COBRA for an additional 18 months (see Associate Leave Standard Operating Policy for details).

You may not change, drop or add medical coverage during a leave of absence, unless you experience a Qualified Family Status Change. Then you must follow the guidelines for changing coverage depending on the type of event. Refer to the "Qualified Family Status Change" section at the beginning of this booklet for more information.

If you become eligible to participate in the Plan while you are on a medical leave of absence, you must still enroll within the applicable enrollment periods. Effective dates will also be the same as if you were actively working. If you fail to enroll within the applicable enrollment periods, then you must wait until the next annual enrollment unless you experience a Qualified Family Status Change or an event that qualifies for special enrollment.

When Coverage Ends

Associate Coverage

Unless otherwise specified in this SPD, Associate coverage ends on the earliest of the following:

- The last day of the month in which your employment ends, including retirement
- The last day of the month in which eligibility stops
- The last day of the month in which you become covered under another plan (once you notify the Associate Service Center)
- When required contributions stop being made
- When the Plan ends

Dependent Coverage

Unless otherwise specified in this SPD, Dependent coverage ends on the earliest of the following:

- The last day of the month in which eligibility ends for you
- The last day of the month in which a Dependent no longer meets the definition of an eligible Dependent*
- The last day of the month in which coverage ends
- When required contributions stop being made
- When a Dependent becomes covered as an Associate under this Plan or another Medical Plan*
- For a spouse, the last day of the month of divorce or annulment*

**It is the Associate's responsibility to notify the Associate Service Center of these events.*

If the Associate dies while covered, eligible Dependents' coverage will continue under COBRA for up to three months after death, at no cost to the family.

COBRA

If coverage for you and/or your Dependents ends, eligibility to continue group coverage under COBRA may apply. This optional continuation of group health care coverage is available as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Refer to the "Continuation of Coverage" section at the beginning of this booklet for more information.

Submit written medical/behavioral health appeals and/or grievances to:

In-Network Appeals and Grievances
Kaiser Foundation Health Plan, Inc. 501 Alakawa St. Honolulu, HI 96817 Fax: (808) 432-7517 Email: KPHawaii.Appeals@kp.org If you have questions, call (800) 966-5955

Out-of-Network Appeals and Grievances
Kaiser Permanente Added Choice P.O. Box 261205 Plano, TX 75026 Fax: (808) 432-7517 Email: KPHawaii.Appeals@kp.org If you have questions, call (800) 966-5955

Refer to the "Claims" section at the beginning of this booklet for additional information.

Claims and Appeals Review

Kaiser will review your claim and make a decision within the allowable timeframe listed below.

Type of Claim	Decision Timeframe for Review of Claims and Appeals
Urgent Claims	The Plan will notify you within 72 hours of any denial. If additional information is needed, the Plan will notify you within 24 hours and allow you 48 hours to respond. The Plan will make a determination within 48 hours of the earlier of: receipt of the information or the end of the period you were given to provide information. The Plan will make a decision on any appeal within 72 hours.
Concurrent Claims	The Plan must notify you prior to the end of an authorized treatment if the benefit is reduced or terminated. If you request to extend a treatment beyond the prescribed course and it involves an urgent care claim, you must make the request at least 24 hours prior to the end of the prescribed treatment and the Plan will make a decision within 24 hours of receipt of your request. If you request to extend a treatment and it does not involve an urgent care claim, the Plan will make a decision within 15 days. You will have 180 days following receipt of a denial to request an appeal. The Plan will make a decision on any appeal within 15 days, or if it involves an urgent care claim, within 72 hours. You will have 60 days following receipt of a denial to request a second appeal. The Plan must make a decision on the second appeal within 15 days.
Pre-service Claims	The Plan must notify you within 15 days of any denial, or send written notice for a 15-day extension. If an extension is needed due to lack of information from you, you will have 45 days from receipt of the notice to provide the information. You have will 180 days following receipt of a denial to request an appeal. The Plan must make a decision on any appeal within 15 days. You will have 60 days following receipt of a denial to request a second appeal. The Plan must make a decision on the second appeal within 15 days.
Post-service Claims	The Plan must notify you within 30 days of any denial, or send written notice for a 15-day extension. If the extension is needed due to lack of information from you, you will have 45 days from receipt of the notice to provide the information. You will have 180 days following receipt of a denial to request an appeal. The Plan must make a decision on any appeal within 30 days. You will have 60 days following receipt of a denial to request a second appeal. The Plan must make a decision on the second appeal within 30 days.

Other Coverage

Continuation of Coverage during a Leave of Absence

According to the Company's Associate Leave Standard Operating Policy, while you are on a leave of absence, your Medical Plan benefits will continue for the first six months of your leave as long as you remain eligible. If you do not

Claims

Filing a Claim

Claims for benefits under the Plan must be submitted to Kaiser Permanente Added Choice using the forms available through the Added Choice Helpline (800) 238-5742. In some cases, the provider will file claims for you.

Type of Claim	How to File Claim
Non-emergency Claims (For reimbursement)	Mail claim form and appropriate documentation to: Kaiser Permanente Added Choice P.O. Box 261205 Plano, TX 75026
Emergency Care Claims	Call the Added Choice Helpline at (800) 238-5742 to obtain an emergency care claim form or write to: Kaiser Permanente Added Choice Attn: Claims Administration 80 Mahalani St. Wailuku, HI 96793
Pre-service Claims (For services and supplies that you have not received)	Call (800) 238-5742 and select option two or mail claim form and appropriate documentation to: Added Choice Review 14770 N. 78th Way Scottsdale, AZ 85260

Payment of Claims

After Kaiser receives complete claim information, payment will be made to the appropriate payee:

- Directly to the provider when the provider assumes responsibility for the claim; or
- Directly to the Participant for reimbursements of qualified payments made by the Participant.

Benefits for covered Dependents after the covered Associate's death will be paid to one of the following:

- The surviving spouse;
- The Dependent child who is not a minor, if there is no surviving spouse;
- A Hospital or a person who submits charges on behalf of Dependents, for services covered under this Plan; or
- The legal guardian of the Dependent.

Filing an Appeal

You have the right to appeal or file a grievance for any denied claim. You may authorize, in writing, a representative to act on your behalf in filing your appeal or grievance. Your appeal/grievance must be in writing and should include:

- The covered Associate's name, address and telephone number
- All information from the covered Associate's ID card as it appears
- The name of the person for whom the claim applies and the date of service
- The name and contact information for the provider and place of service
- Description of the service and the charge for the service
- Statement of opinion as to why the denial was improper
- A copy of the EOB (if available)

You must submit your appeal or grievance within 180 days from receipt of the denial or you waive your right to request a review of the denied claim.

- In vitro fertilization that does not use the spouse's sperm or eggs and does not meet state law requirements
- Services for reversal of voluntary surgical sterilization or tubal ligation

- Medical supplies such as dressing and antiseptics
- Mental health services that are not necessary or reasonably expected to improve the condition, as well as treatment requested or required by an outside agency/body
- Miscellaneous:
  - Charges for completion of claim forms or administrative fees
  - Charges for missed appointments
  - Custodial care
  - Injury or sickness caused by participation in declared or undeclared war, riot, civil disobedience or international armed conflict
  - Services of a person who is a member of the Participant's immediate family or who resides in her/his home, such as a spouse, sibling, parent or child
  - Services given by volunteers or persons who do not normally charge for their services
  - Services given by a licensed pastoral counselor to a member of her/his congregation in the course of her/his normal duties as a pastor or minister
  - Expenses not legally required to be paid
  - Services rendered in conjunction with those of an attending Physician whose services are not covered
  - Services, exams or tests not needed to treat accidental Injury, sickness or pregnancy, except as specifically provided by name in the Plan
  - Services or supplies not specifically listed as Covered Services
  - Telephone consultations
- Non-prescription vitamins
- Occupational therapy supplies
- Prescription drugs self administered and associated with excluded services, as well as drugs used for cosmetic purposes
- Routine foot care
- Services which payment is made or available through Workers' Compensation or similar law
- Travel immunizations
- Treatment of temporomandibular joint dysfunction (TMJ) or Craniomandibular Pain Syndrome
- Vision, including:
  - Eye examinations for contact lenses
  - Radial keratotomy, Photo-refractive keratotomy and similar procedures

  - Inpatient - Benefits for mental health and substance abuse treatment will be limited to a total of 30 days per calendar year;
  - Outpatient - Benefits for mental health and substance abuse treatment will be limited to 24 visits per calendar year; and
  - Non-hospital residential services – Benefits for mental health and substance abuse will be limited to 60 days per calendar year. Benefits for residential substance abuse are limited to two treatment episodes per lifetime
- Physical, occupational and speech therapy limited to 60 outpatient visits per calendar year.
- Prescription drugs prescribed by a physician/licensed prescriber, including:
  - Contraceptive drugs and devices;
  - Diabetic drugs and insulin limited to a 30-day consecutive supply per prescription or refill; and
  - Drugs administered by medical personnel
- Preventive care, including
  - Routine adult physicals; and
  - Well child visits (age 6 – 18)
- Preventive care screenings limited to anemia and lead screening for children, colorectal cancer screening, chlamydia detection, fecal occult blood test, lipid evaluation, newborn metabolic screening, cervical cancer screening, mammography and osteoporosis screening.
- Primary care and specialty care office visits are limited to exams, history and medical decision making
- Transplants, including kidney, heart, heart-lung, liver, lung, simultaneous kidney-pancreas, bone marrow, cornea, small bowel-liver transplants
- Urgent care services where initial care for a sudden illness or injury if temporarily away from Kaiser network to prevent serious deterioration of health.

Exclusions

The following exclusions apply to the Medical Plan, including the Prescription Drug Program.

In addition to any exclusions or limitations described in this SPD, the Plan DOES NOT cover services for:

- Acupuncture treatment
- Alternative medical services not accepted by standard medical practices such as hypnotherapy, behavior testing, sleep therapy, biofeedback, massage therapy, naturopathy, rest cure and aroma therapy
- Artificial aids, corrective aids and corrective appliances such as external prosthetics, braces, orthopedic aids, orthotics, hearing aids, corrective lenses and eyeglasses
- Blood products, derivatives and components except as stated under Covered Services
- Cardiac rehabilitation
- Chiropractic services
- Contraceptive substances and other non-prescription substances used in conjunction with other prescribed drug or device
- Cosmetic services, such as plastic surgery to change physical appearance
- Dental care, such as X-rays, implants, appliances or orthodontia
- Durable medical equipment, such as crutches, canes, oxygen-dispensing equipment, hospital beds and wheelchairs
- Experimental or investigational services
- Infertility services not covered include:
  - Equipment and collection, storage and processing of sperm

The Plan covers the following services:

- Abortions are limited to two per lifetime
- Ambulance services for medically necessary acute care, including air ambulance if medically necessary
- Anesthetics and charges for giving them when administered in an outpatient or inpatient facility
- Blood collection, processing and storage when prescribed by physician for a scheduled surgery, as well as replacement and processing of whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin
- Cosmetic surgery to correct significant disfigurement resulting from an Injury or medically necessary surgery or incident to a covered mastectomy
- Diabetes glucose meters and external insulin pumps
- Dialysis, including physician, facility services, equipment, training and medical supplies for home dialysis
- Durable medical equipment intended for repeated use, primarily used to serve a medical purpose, appropriate for use in the home and generally not useful to a person in the absence of Illness or Injury
- Ear examinations to determine the need for hearing correction
- Emergency medically necessary services covered for initial emergency treatment.
- Eye examinations for eyeglasses
- Family planning, including:
  - Hospital stay (refer to covered hospital services), including routine nursery care for newborn while mother is confined;
  - Prenatal visits at routine scheduled intervals; and
  - Routine post-partum visit
- Home health care, including nurse and home health aide visits when prescribed by a physician
- Hospice care for the care of a terminally ill member, including:
  - Counseling and coordination of bereavement services;
  - Home health aide services;
  - Medical social services;
  - Medical supplies;
  - Nursing care (does not include private duty nursing);
  - Physician services; and
  - Physical, occupational and speech therapy
- Hospital services, including
  - General nursing care and use of operating room;
  - Materials for dressings and casts;
  - Physician and surgical services;
  - Radiation therapy;
  - Respiratory therapy; and
  - Room and board
- Immunizations (in-network only)
- Infertility treatments limited to artificial insemination and in vitro fertilization. In vitro fertilization limited to once per lifetime
- Mental Health:
  - Serious mental health (schizophrenia, schizo-affective disorder, bipolar types I and II, delusional disorder, major depression, obsessive-compulsive disorder and dissociative disorder);

PLAN PROVISION	IN-NETWORK	OUT-OF-NETWORK PARTICIPATING PROVIDER
Serious Mental Illness		
Outpatient	$14 Copayment	20% of MAC
Inpatient	No charge	20% of MAC
Mental Health Services (does not include serious Mental Illness)		
Outpatient	20% of applicable charges (limited to 24 visits per calendar year)	20% of MAC (limited to 24 visits per calendar year)
Inpatient	20% of applicable charges (limited to 30 days per calendar year)	20% of MAC (limited to 30 days per calendar year)
Substance Abuse Services		
Outpatient	$14 Copayment	20% of MAC
Inpatient	No charge	20% of MAC
Residential	20% of applicable charges (limited to 60 days per calendar year)	20% of MAC (limited to 60 days per calendar year)
Additional Services		
Internal/External Prosthesis	20% of applicable charges	20% of MAC
Durable Medical Equipment (including diabetes equipment)	20% of applicable charges	20% of MAC
Prescription Drugs (excludes contraceptive drugs and devices)		
Retail (30-day supply)	$10 Copayment	20% of charge, but not less than $10 per prescription. Only available at participating pharmacies.
Mail order[2] (90-day supply)	$20 Copayment	Not covered

[1] *Emergency surcharge fees are not covered.*
[2] Applies to refills for most maintenance drugs. The mail-order program does not apply to certain drugs and mailing is limited to addresses inside the *Hawaii Service Area.*

Covered Services

The following Covered Services apply to the Medical Plan, including the Prescription Drug Program.

Covered Services must comply with the following standards. The service or treatment must be:

- Medically Necessary;
- Recommended and approved by a Kaiser Permanente Physician; and
- Received from Kaiser Permanente facilities within the Hawaii service area.

If you have questions about Covered Services and/or exclusions, call Kaiser at (800) 238-5742.

You and your Health Care Provider share responsibility for deciding which services and supplies are received. However, the Plan provides benefits only for Covered Services.

The recommendation and approval of a diagnostic or treatment alternative by the attending Physician does not mean the procedure is covered by the Plan.

Medical Plan Highlights

Plan Provision	In-Network	Out-of-Network Participating Provider
Deductible	$0	$100 Individual/$300 Family
Out-of-Pocket/Supplemental Charges Maximum	$2,000 Individual/$6,000 Family	$1,000 Individual/$3,000 Family
Lifetime Maximum	None	$1 million
Preventive Services		
Well-child Office Visit (birth – age 5)	$15 Copayment	20% of MAC (Deductible waived)
Well-child Office Visit/Routine Adult Physicals (age 6 and older)	$15 Copayment	20% of MAC
Immunizations (birth – age 18)	No charge for most immunizations	0% (Deductible waived)
Immunizations (age 19 and older)	$10 per dose	20% of MAC
Outpatient Services		
Office Visits	$15 Copayment	20% of MAC
Routine Obstetrical Care	No charge if pregnant	20% of MAC
Abortions (elective abortions are limited to 2 per lifetime)	$15 Copayment	20% of MAC
Outpatient Surgery and Procedures	$15 Copayment	20% of MAC
Lab, Imaging and Testing	10% of applicable charges	20% of MAC for X-rays and laboratory exams
Administered Drugs	No charge for most drugs (must pay office visit copay)	20% of MAC
FDA-approved Contraceptive Drugs and Devices	50% of applicable charges	20% of MAC (limited to oral, injectable and implantable contraceptive devices)
Inpatient Services		
Hospitalization (includes Room and Board, Physicians' medical and surgical services, and anesthesia services)	No charge	20% of MAC
Lab, Imaging and Testing	10% of applicable charges	20% of MAC for X-rays and laboratory exams
Administered Drugs	No charge for most drugs administered during Hospital stay	20% of MAC
Skilled Nursing Care		
Skilled Nursing Care	No charge (limited to 60 days per benefit period)	20% of MAC (limited to 120 days per calendar year)
Emergency Services[1] (initial treatment only)		
Inside Service Area	$50 Copayment, plus other applicable plan charges	
Outside Service Area	20% of applicable charges, plus applicable plan charges	
Ambulance	20% of applicable charges, plus applicable plan charges	20% of MAC

Types of Coverage

When you enroll, select your type of coverage depending on the number of eligible individuals to be covered.

TYPE OF COVERAGE	ELIGIBLE INDIVIDUALS
Associate	Associate only
Associate and Child(ren)	Associate and one or more eligible Dependent child(ren)
Associate and Spouse/Domestic Partner	Associate and spouse/domestic partner only
Family	Associate and spouse and one or more eligible Dependent child(ren)

Call the Associate Service Center at (800) 288-6353 for questions about eligibility and enrollment.

Terms to Know

Your medical coverage with the Plan takes into account several factors when determining the expense to you. As you review coverage and expenses, it will help to know the terms listed below. Additional important terms found throughout the Medical Plan are defined in the Glossary at the back of this booklet.

- **Copayment –** Set dollar amount paid by you or your Dependents for specific services received. Copayments apply on a per-visit, per-patient basis. Copayments do not accumulate toward the annual Out-of-Pocket Maximum and continue to be charged after the annual Out-of-Pocket Maximum has been satisfied.
- **Covered Services** – Those services for which the Plan will pay a portion of the cost.
- **Deductible** – Amount you must pay for certain out-of-network Covered Expenses before the Plan begins to pay benefits for that service(s). The Plan Year Deductible does not take into account payments you and/or your covered Dependents make toward Copayments.
  - With Associate only coverage or Associate and spouse coverage, each Participant must meet the Deductible separately each Plan Year.
  - With family or Associate and child(ren) coverage, the combination of expenses for all Covered Family Members applies toward meeting the Deductible, regardless of family size.
- **MAC (Maximum Allowable Charge) –** is the lesser of the reasonable charge, negotiated rate or actual billed charges. You are responsible for charges that exceed the MAC when receiving services from non-participating providers.
- **Out-of-Pocket Maximum** – A cap on the amount of expenses that you pay for out-of-network Covered Services, not including Deductibles and/or Copayments.

Prior Authorization

Whenever you plan to seek medical services, fill a prescription or receive treatment for mental health or substance abuse, it is best to consult the Plan to make sure a prior authorization is not required. By obtaining prior authorization, you help ensure that you will receive maximum benefits under the Plan. When you have questions about prior authorizations or you need to request a prior authorization, call Kaiser at (800) 238-5742.

If you fail to obtain prior authorization for applicable services, benefits will be reduced by $300 each time up to $1,000 per calendar year.

Kaiser Medical Plan (Hawaii Associates)

Kaiser Permanente Added Choice POS
(800) 238-5742
www.kaiserpermanente.org/hawaii

This summary is only a brief highlight of benefits provided under the Kaiser Permanente Added Choice POS. It is not intended to provide all Plan information. For more details, refer to the Hawaii Added Choice Certificate of Insurance and the Kaiser Permanente Added Choice Member Handbook which will be sent to you upon enrollment.

The Kaiser Permanente Added Choice POS Plan is offered to eligible Associates in Hawaii only.

This Plan must adhere to Hawaii state laws. Because the laws may change, the Plan will be administered according to new laws when applicable.

Eligibility and Enrollment

Associate Eligibility

- All Hawaii Associates are eligible for coverage under this Plan the first of the month after completing one full calendar month of service. Part-time and Temporary Associates are eligible for Associate only coverage.

Dependent Eligibility

- Regular Full-time Associates may cover eligible Dependents, including legal spouse, eligible Dependent children, including physically or mentally disabled children (defined in the Hawaii Added Choice Certificate of Insurance), and a domestic partner.

Special Note for Part-time Associates: If you do not work enough hours to pay for your bi-weekly deductions for two consecutive pay cycles, your coverage will be dropped.

If you want to enroll after the eligibility timeframes, contact the Associate Service Center and ask for an Enrollment Request Form. The form must be completed before the enrollment request will be considered. If your claim initiation/appeal to add coverage after the eligibility timeframe is approved, your benefit deductions will be taken on an after-tax basis for the remainder of the Plan Year.

How and When to Enroll

- Complete the on-line enrollment process within 30 days after your date of hire, during annual enrollment or upon/after a Qualified Family Status Change
- If you waive coverage, an HC-5 Form will be sent to you. If the form is not returned, your coverage will automatically default to Associate only coverage and will stay in effect unless you experience a Qualified Family Status Change or until the next annual enrollment.

If you fail to submit the HC-5 form, you'll automatically be enrolled in the plan at the Associate only coverage level and pre-tax contributions will be taken from your paycheck.

Continuation of Coverage during a Leave of Absence

According to the Company's Associate Leave Standard Operating Policy, while you are on a leave of absence, your Medical Plan benefits will continue for the first six months of your leave as long as you remain eligible. If you do not return from leave after six months, you may elect to continue your coverage under COBRA for an additional 18 months. If you are on Military Leave, you may elect to continue your active coverage for up to twelve months at the same cost as active associates and may then continue coverage at the cost provided under COBRA for an additional 18 months (see Associate Leave Standard Operating Policy for details).

You may not change, drop or add medical coverage during a leave of absence, unless you experience a Qualified Family Status Change. Then you must follow the guidelines for changing coverage depending on the type of event. Refer to the "Qualified Family Status Change" section at the beginning of this booklet for more information.

If you become eligible to participate in the Plan while you are on a medical leave of absence, you must still enroll within the applicable enrollment periods. Effective dates will also be the same as if you were actively working. If you fail to enroll within the applicable enrollment periods, then you must wait until the next annual enrollment unless you experience a Qualified Family Status Change or an event that qualifies for special enrollment.

COBRA

If coverage for you and/or your Dependents ends, eligibility to continue group coverage under COBRA may apply. This optional continuation of group health care coverage is available as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Refer to the "Continuation of Coverage" section at the beginning of this booklet for more information.

Under this subrogation provision, Participants have the following obligations:

- To seek recovery from a third party (or her/his insurance) of all amounts in connection with Plan benefits provided, arranged or paid, and to notify the Plan within 10 working days of any such action taken by him/her.
- To refrain from doing anything to impair, prejudice or discharge the Plan's right of subrogation.
- To assist the Plan as necessary to enforce its right of subrogation.
- To pay the Plan any amounts received to the extent of benefits provided by the Plan to which the Plan is entitled because of its right of subrogation.
- To provide in a timely fashion, information requested by the Plan.

When Coverage Ends

Associate Coverage

Unless otherwise specified in this SPD, Associate coverage ends on the earliest of the following:

- The last day of the month in which your employment ends, including retirement
- The last day of the month in which eligibility stops
- The last day of the month in which you become covered under another plan (once you notify the Associate Service Center)
- When required contributions stop being made
- When the Plan ends

Dependent Coverage

Unless otherwise specified in this SPD, Dependent coverage ends on the earliest of the following:

- The last day of the month in which eligibility ends for you
- The last day of the month in which a Dependent no longer meets the definition of an eligible Dependent*
- The last day of the month in which coverage ends
- When required contributions stop being made
- When a Dependent becomes covered as an Associate under this Plan or another Medical Plan*
- For a spouse, the last day of the month of divorce or annulment*

**It is the Associate's responsibility to notify the Associate Service Center of these events.*

If the Associate dies while covered, eligible Dependents' coverage will continue under COBRA for up to three months after death, at no cost to the family.

Other Coverage

Continued Coverage for Hospitalization after Coverage Ends

If hospitalized when coverage ends, benefits will continue to be payable for inpatient Hospital or related Hospital facility Room and Board provided that the expenses are not payable under any other group plan and the entire hospitalization is for the same cause as the admission. Charges other than Room and Board are the patient's responsibility.

This continued coverage applies only until the earliest of:

- The date the maximum benefits have been paid;
- The date the inpatient Hospital stay ends; or
- The date the person becomes covered for that condition under another group plan, including Medicare.

remain covered under this Plan, each should enroll in Medicare when first eligible. Medicare may pay certain benefits in addition to those under this Plan. Additionally, late enrollment in Medicare may result in a continuing surcharge on Medicare premiums after enrollment.

Refund to the Plan for Overpayment of Benefits

Whenever payments have been made by the Plan in excess of the maximum amount payable under the Plan's provisions, Participants must pay back the Plan for the amount paid in excess.

If the Participant or any other person or organization that was paid does not promptly reimburse the full amount, the Plan may reduce the amount of any future benefits payable. The reductions will equal, but not exceed, the amount the Plan paid in excess of the amount it should have paid. The Plan may have other rights in addition to the right to reduce future benefits.

Recovery of Third Party Liability Claims

The Plan has the right to reimbursement from covered Associates, their Dependents, or another legally responsible person or entity for all benefits paid by the Plan that were associated with an Injury or Illness for which a third party is liable to the Participant. The Plan has the first priority right to reimbursement from any insurance coverage, including recovery from Uninsured or Underinsured Motorists coverage, judgment, settlement or otherwise. This right to reimbursement remains in effect whether such payment satisfies, in full or in part, the Participant's loss (i.e., regardless of whether the Participant has been "made whole" by the payment) or regardless of how a recovery is characterized. The reimbursement to the Plan shall not be reduced due to the fees or expenses of legal counsel retained by the Participant.

If the Participant or any other person or organization that was paid does not promptly reimburse the full amount, the Plan may reduce the amount of any future payable benefits. Participants have the same obligations as listed under the "Subrogation" section of this SPD.

Reductions will equal the amount the Plan paid in excess of the amount it should have paid. In the case of recovery from a source other than this Plan, the refund will equal the amount of recovery up to the amount paid under this Plan. The Plan may have other rights in addition to the right to reduce future benefits.

Subrogation

Subrogation is a cost-containment feature that shifts the expense of treating accidental injuries back to the party or insurer properly responsible for those costs. When the Plan pays for accidental injuries, subrogation allows the Plan to recover, by legal action if necessary, those payments directly from the responsible third party.

Subrogation will result in savings to the Plan for the benefit of all Participants because the cost of treatment for sickness or Injury will be paid by the person who is legally responsible for such payment. The Plan is also subrogated and has a right of subrogation to any underinsured, insured, uninsured or any other insurance plan under which Participants are covered.

Any settlement which releases all the claims Participants have against any of the parties noted above is deemed to be for damages on account of the expenses incurred as a result of the Injury or Injuries, no matter how the settlement documents may denominate the settlement and regardless of whether the injured Participant is fully compensated ("made whole"). The Plan's recovery shall not be reduced due to the fees or expenses of legal counsel retained by the Participant.

How and When to Enroll

- If you are a Regular Full-time Associate, you must complete the on-line enrollment process within 30 days after your date of hire, during annual enrollment or upon/after a Qualified Family Status Change
- If you are a Regular Part-time Associate, you must complete the on-line enrollment process within 30 days prior to your eligibility date, during annual enrollment or upon/after a Qualified Family Status Change

Types of Coverage

When you enroll, select your type of coverage depending on the number of eligible individuals to be covered.

TYPE OF COVERAGE	ELIGIBLE INDIVIDUALS
Associate	Associate only
Associate and Child(ren)	Associate and eligible Dependent child(ren)
Associate and Spouse/Domestic Partner	Associate and spouse or domestic partner only
Family	Associate and spouse or domestic partner and one or more eligible Dependent child(ren)

Call the Associate Service Center at (800) 288-6353 for questions about eligibility and enrollment.

ID Cards

You will not receive an ID card if you are enrolled in the Vision Care Plan; however you may visit VSP's website and print a personalized VSP benefit reference card at www.vsp.com. Since you will not receive an ID card, you should call VSP provi[illegible]irectly to verify your coverage.

Terms to Know

Your coverage with the Vision Care Plan takes into account several factors when determining the expense to you. As you review coverage and expenses, it will help to know the terms listed below. Additional important terms found throughout this Vision Care Plan section are defined in the Glossary at the back of this book.

- **Copayment** – Set dollar amount paid by you or your Dependents for specific services received. Copayments apply on a per-visit, per-patient basis.
- **Covered Services** – Those services for which the Plan will pay a portion of the cost.
- **VSP Doctor** – A licensed optometrist or ophthalmologist who has contracted with VSP to provide vision care services and/or vision care materials to individuals insured by VSP.
- **Non-Network Provider** - Any optometrist, optician, or ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or materials to individuals insured by VSP.

To find a local provider in the VSP Network, call (800) 877-7195 or go to www.vsp.com.